

STATE OF TENNESSEE
DEPARTMENT OF HEALTH



LOST OR STOLEN PROPERTY REPORT

(To be completed immediately upon discovery of loss by person to whom the property is assigned)

Date: _____, 20____

Completed by: _____

State Tag No.: _____

Name: _____

Serial No.: _____

Title: _____

Property
Description: _____

Department: _____

Division: _____

Telephone Number: _____

Budget Code: _____ Location: _____

Book Value: \$ _____

Supervisor Approval: _____

Date of Loss: _____

Name: _____

Place of Loss: _____

Title: _____

DETAILS OF LOSS (Circumstances, Cause, etc.): _____

If Stolen, What Law Enforcement Agencies Were Notified? _____

Incident Report #: _____

Does Department Have a Claim Against Any Employee or Other Person for Loss of This Item (Due to Negligence, Etc.)? _____

If Yes, Give Name, Address and Basis for Claim on Reverse Side.

Approved for Removal from Active File: _____

(Location *Manager*)

D a t e : _____, 2 0____

AUDIT AND INVESTIGATIONS COMPLETE

Approved for Removal from Active File: _____

(*Audit and Investigations*)

Date: _____, 20____

BUSINESS ADMINISTRATION COMPLETE

Depreciated Value at Time of Removal: \$ _____ Date Transferred: _____, 20____

Initials